Legislative Snapshot:
Number 22

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MEDICAID

by
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MEDICAID

A Snapshot of 1980 Laws

Kathleen Brennan

1980 may be the last year for some time in which state Medicaid programs show a net expansion of services, reimbursement and eligibility. The nearly 100 laws passed in the 50 state legislatures can be divided into 2 categories: laws expanding service coverage and eligibility and increasing provider reimbursement, and legislation improving the management of the system. In 1980 the majority of the enactments dealt with broadening the programs' scope and benefits; reports on 1981 legislative and departmental activities (see IHPP's Recent and Proposed Changes in State Medicaid Programs: A Fifty State Survey) indicate that this trend, for the most part, has reversed.

Several amendments were enacted by states altering the administrative structures of their programs. Generally, such amendments were designed to assist the state in controlling costs through various strategies, such as stricter fraud and abuse enforcement and recovery of medical assistance costs from third party payers. States are justifiably concerned with Medicaid costs. Federal-state expenditures rose 827 percent (unadjusted for inflation) between 1970 ($2.2 billion) and 1979 ($20.4 billion). At present, approximately 22 percent of the federal health budget and 44 percent of state health care expenditures go for the provision of Medicaid services. Without drastic changes in the structure of the program, Medicaid expenditures are projected to continue to rise at nearly twice the rate of state budgets.*

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* "Perspectives on the Impending Changes in Government Funding for Medical Services," by Robert J. Blendon and Thomas W. Moloney, 1981 Commonwealth Fund Forum, Illinois, August 1981. Also, "Medicaid Data Book," Health Care Financing Administration, 1981.

SERVICES

Federal Medicaid law requires certain services (e.g., inpatient hospital care, physician services) to be covered, although the States may limit the scope of coverage provided. In addition, States may cover a number of optional services (e.g., eyeglasses, podiatrists). Most changes in Medicaid services originate in, and are implemented by, the state Medicaid agencies. However, six States did enact measures to revise the roster of covered services. Four 1980 statutes expand covered benefits while three others cut back the scope of service. **California** added certified paramedic services and adult day care centers to the Medi-Cal (California's medical assistance program) program. **Louisiana** passed two resolutions: SCR 126 authorizing a feasibility study of financing the use of oxygen in nursing homes; and HCR 65 which directs the Department to reimburse for the services of licensed podiatrists.

Michigan tightened the requirements for covering transportation and nursing services by stipulating that such services be related to medical, surgical or obstetrical care (HB 5875). **Florida** removed audiologists from the list of covered providers, while **Iowa** directed the Medicaid Department to develop rules to eliminate payments for laxative drugs and limit orthodontia, eyeglasses and frames, and dentures.

ELIGIBILITY

Sixteen measures pertaining to Medicaid eligibility were approved by the legislatures during the 1980 sessions. Ten of the laws expanded entitlement provisions; six others made reductions in eligibility.

California and **Louisiana** each enacted three pieces of legislation broadening Medicaid eligibility. Two of **Louisiana's** enactments dealt with retaining eligibility for persons who lose eligibility due to cost-of-living adjustments in retirement benefits. SB 209 applies to state and local benefits while HCR 80 concerns federal SSI payments. Another **Louisiana** resolution (SCR 24) petitions the federal government to increase maximum income levels for Titles XV and XIX. In **California**, the legislature extended special Medi-Cal eligibility to dialysis patients, established "spend-down" provisions for the working disabled and added income eligible persons in city or county jails or detention facilities to the Medi-Cal rolls. This last provision was also authorized in **Maryland** (SB 542).

Other 1980 measures were passed in:

- **Indiana**—reworked computation of available assets to increase eligibility;
- **Iowa**—changed maximum income for the medically needy to 300 percent of the maximum individual SSI allowance; and
- **Missouri**—enabled pregnant women who will be eligible for AFDC after the child is born to receive medical assistance for prenatal care.

Of the six successful legislative efforts to control Medicaid entitlement, three (**North Carolina**, HB 1590; **Louisiana**, HB 1686; and **Connecticut**, HB 5121) include provisions to maintain and collect accurate and timely recipient eligibility data. In addition, **Florida** now includes all interest income in determining assets (HB 1812). In **Connecticut**, parental income is considered available for the purpose of establishing income eligibility for Medicaid to children under 21 living with their parents.

REIMBURSEMENT

Although specific reimbursement issues are usually the domain of the executive, not the legislature, six state legislatures did approve measures changing their reimbursement policies. Two of the enactments pertain to payments for pharmaceuticals. **Missouri's** HB 399 outlines the State's reimbursement methodology for pharmacies; in addition, the law permits the Department to pay generic prices for certain nongeneric pharmaceuticals. The **North Carolina** legislature appropriated funds to increase the dispensing fee paid to pharmacists for each prescription.

California devised a system for negotiating prospective rates for Medi-Cal. **Kentucky** and **Maryland** both passed statutes designed to standardize medical assistance payments. In **Maryland** (HB 1726), hospital-affiliated long-term care facilities must be paid in the same manner as hospitals. SB 53 in **Kentucky** prevents reimbursement rates from varying on a geographic basis throughout the State.

The **Alaska** legislature approved HJR 83 which requests more flexibility in federal Medicaid reimbursement regulations to allow state plans to be responsive to geographical differences in medical care costs.

ADMINISTRATION

Fraud and Abuse

In 1979, 10 States enacted legislation establishing a Medicaid fraud authority or amending an existing authority. The issue was no less prominent in 1980: 7 States passed 11 laws dealing with Medicaid fraud and abuse.

Florida was especially active in this area. HB 1312, setting out the responsibilities and powers of the Medicaid fraud unit, and HB 1812, dealing with offenses and sanctions, together gave the State a comprehensive fraud detection and prosecution authority.

Other significant activities include:

- **Alabama's** sanctions for provider and recipient fraud (HB 488 and HB 601, respectively). In addition, HB 593 allows the state Medicaid agency to distribute photo ID cards and strengthen the eligibility verification process.
- **California** providers who are suspended from participation in Medicare or the Medicaid program in another jurisdiction because of a criminal or civil conviction are also suspended from Medi-Cal.
- In another action (AB 1180) the **California** legislature empowered the Department to issue Medi-Cal ID cards to persons engaged in investigating fraud and abuse practices.
- **Hawaii's** legislature expanded the definition of Medicaid fraud and strengthened the penalties for fraud and abuse.
- **New Mexico** established a conflict of interest policy for decision-makers in the Department of Human Services who are involved in the Medicaid programs.
- **Maryland** reduced its statute of limitations for the prosecution of Medicaid fraud to three years.

Third Party Recovery

Under Medicaid, third party liability exists if there is any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical expenses for a Medicaid recipient. Medicaid is designed to be the payer of last resort. **Alabama, Indiana, Louisiana, Maine, North Carolina** and **Tennessee** enacted measures allowing States to recover Medicaid payments from recipients or third parties. These 1980 enactments differ materially from those of the preceeding year. The legislation in 1979 specifically focused on recovery from estates or third parties who caused the condition treated under the Medicaid program. In 1980 the trend was toward a more general assignment provision, in which the act of applying for benefits meant that the applicant was empowering the Medicaid agency to collect from any liable third party payer (**Alabama, Kentucky, Louisiana, North Carolina** and **Tennessee**).

Transfer of Assets

Prior to the passage of federal legislation in December 1980 (PL 96-611), five States enacted measures prohibiting the transfer of assets at less than full market value. The **Idaho** resolution merely requested that the federal government outlaw such transfers, while the **Virginia** legislature enjoined the Board of Health to investigate whether its present law is a sufficiently strong disincentive to transferring assets. **Iowa's** strict approach defines transfer of assets as Medicaid fraud and assesses penalties for the person who accepts the transfer as well as the one making it. HB 137 in **Maryland** permits long-term care facilities to involuntarily remove residents who lose Medicaid eligibility because they disposed of assets for less than market value.

Therapeutic Leave

Four States focused their attention on financing therapeutic leave for institutionalized Medicaid patients. Therapeutic leave enables institutionalized patients to leave the facility to visit friends or relatives or to seek acute or rehabilitative treatment without losing their place in the residential facility. Generally, States with therapeutic leave programs limit their medical assistance payments for maintaining a vacant bed to less than 30 days a year.

The **California** legislature set out guidelines for the Department to use in setting up a therapeutic leave program. Medi-Cal must pay for at least 30 leave days per year but the vacant bed must be reimbursed at less than the institution's full rate. In **Connecticut**, HB 5545 provides that a long-term care facility must keep a bed available for a hospitalized patient as long as payment is made by Medicaid or other third party. If the payment period elapses before the patient returns to the facility, he or she must be provided with the first available bed. **Ohio's** Medicaid program currently pays for 24 days of therapeutic leave in a 12-month period; this was amended in 1980 to allow for more therapeutic leave for residents in intermediate care facilities for the mentally retarded (HB 964). The **Ohio** legislature also approved HB 176 which gives patients greater flexibility to allocate the 24 days among different types of therapeutic leave.

Florida passed SB 1218, which upholds the right of Medicaid patients to take therapeutic leave (within limits set by the facilities, physicians, Medicare and Medicaid).

Personal Allowances

The personal allowances retained by institutionalized Medicaid patients were affected by laws passed in three states. **Indiana** tightened the qualifications required for the receipt of an allowance. **Rhode Island** appropriated funds to increase the allowance from $25 to $30 a month while the **Louisiana** legislature urged the Department to follow the same course.

Prepaid Plans for Medicaid Recipients

California, the innovator in the use of prepaid health plans to serve its Medi-Cal population, passed three measures amending its authorization for this program:

- SB 1766 pertains to sanctions for contractors not performing to the satisfaction of the Department;
- SB 1697 permits the Department to contract with nonprofit hospital service plans for prepaid services; and
- SB 1637 sets out a process to notify Medi-Cal recipients of the availability of prepaid health plans in the Medi-Cal program.

North Carolina's legislature empowers the Department of Human Services to alter the state Medicaid plan to allow contracting with prepaid health providers.

Copayments

Although increasing consumer cost sharing was debated extensively within state governments, only three states actually enacted measures relating to copayments in 1980. The **Hawaii** legislature established a study on the efficacy of using copayments, laying particular stress on copayments for emergency room services. **Alabama** passed two separate ordinances on copayments. HB 596 authorizes practitioners to collect a $2 payment for each service episode, while HB 595 mandates that the Department charge the highest copayment allowed by federal law for prescription drug purchases. **Iowa's** HF 2580 directs the Department to establish a copayment of $0.50 per prescription as well as copayments on a number of optional services.

OTHER ACTIVITIES

1980 enactments in **California, Michigan** and **Utah** apply to state and county relationships in the Medicaid process. **California** and **Michigan** both require that counties reimburse the State for a portion of the state share of certain services provided by county-owned or operated entities. SB 53 in **Utah** denies entitlement to county indigent care benefits to persons eligible for Medicaid and other federal/state programs.

Prompt payments to providers are viewed as a way of increasing or maintaining provider participation in the Medicaid program. AB 2316 in **California** mandates that fiscal intermediaries process claims quickly and make weekly disbursements to providers. The **Missouri** Department may pay providers by wire transfer rather than by check (HB 1840).

Two other States added clauses disallowing discrimination against Medicaid recipients. In **Alabama**, insurers (broadly defined to include HMOs and self-insurers) may not cut back or eliminate coverage for persons also covered by or eligible for Medicaid. Nursing home discrimination is the subject of **Connecticut's**

HB 5548. Long-term care facility reimbursement levels may be cut if the facility discriminates against Medicaid recipients in its admissions.

Alabama and **Hawaii** adopted resolutions requesting action by the federal government. **Alabama** made a number of specific requests for greater flexibility in the administration of its Medicaid program, including the ability to charge copayments for all services, deny eligibility to program abusers, determine reimbursement levels and administrative procedures at the state level and expand family responsibility for the costs of nursing home residents (SJR 19). The legislature in **Hawaii** requested that the federal government pick up a greater portion of the costs of providing long-term care.

Indiana was the sole State to change its family responsibility provisions. The language of the statute now requires that spouses and parents "having sufficient income" help pay for medical care rather than those who are "able" to do so.

Other alterations in state administrative procedures include:

- the establishment of a preadmission screening process for actual or potential Medicaid recipients in **Minnesota** (SB 702);
- **New York's** SB 9800-A, which separates inspections for quality of care and financial integrity of nursing homes;
- **California's** requirement that the State develop Medi-Cal regulations for intermediate care facilities for the developmentally disabled (AB 2845); and
- HB 2324 in **Tennessee**, which empowers the Primary Health Care Advisory Board to designate primary care centers as Medicaid providers.

STUDIES

It is not unusual for States to authorize and fund studies and demonstration projects before making substantial changes in their Medicaid programs. Studies established by legislative mandate during the 1980 sessions include:

- **Alabama**—appropriated funds to the Joint Committee to Study the Rising Cost to the State of the Medicaid Program;
- **California**—authorized a legislative committee investigation of Medi-Cal claims processing procedures;
- **California**—appropriated funds for a demonstration project using patient treatment profiles and prior authorizations to control Medi-Cal utilization;
- **Florida**—continued its program of using local agency contributions to increase Medicaid outpatient benefits;
- **Hawaii**—requested assistance from the federal Health Care Financing Administration to produce statewide seminars on problems facing the Medicaid program; another study centers on cost containment strategies;
- **Indiana**—established a demonstration program to fund home health care for the aged;
- **Iowa**—required that the Department commission a study on alternative methods of cost reimbursement for long-term care;
- **Kentucky**—directed the legislative staff to conduct a study with emphasis on the adequacy of the program and cost containment strategies;
- **Maryland**—mandated a general review of the program, with particular emphasis on establishing guidelines and priorities;

- **Tennessee**—set up two studies; one to investigate the feasibility of using the Medicaid Department to certify the necessity of nonemergency admissions, the other to focus on strategies to reduce utilization without endangering recipients' health.

STATE-BY-STATE SUMMARY OF 1980 MEDICAID LEGISLATION

ALABAMA

HB 488, Act 539

This act makes it a felony to make false statements in order to receive payments from Alabama's Medical Services Administration and sets up sanctions including fines less than $10,000 and prison sentences of 1 to 15 years.

Furthermore, these provisions apply to persons taking bribes and kickbacks for referring Medicaid patients or purchasing goods and services paid for with medical assistance payments. Persons offering such bribes and kickbacks are subject to the same penalties. This act does not apply to rebates that are properly disclosed and reflected in the provider's costs or charges.

HB 590, Act 124

Insurance companies are barred from including provisions that would reduce benefits for persons also covered or eligible to be covered by the Alabama Medicaid program.

Act 124 pertains to all private insurers including 1) commercial insurance companies offering health or casualty insurance, 2) prepaid health plans, and 3) self-insured and self-funded plans.

HB 593, Act 183

Alabama's Pensions and Security Agency is empowered to issue ID cards with color pictures to all Medicaid eligibles in order to establish real-time verification of Medicaid eligibility. To carry out this Act, the Department will utilize a data processing system provided by the Alabama Criminal Justice Information Center.

The Agency must make every reasonable attempt to protect the confidentiality of the medical assistance beneficiaries.

HB 595, Act 155

Under this legislation, Medicaid recipients are required to pay the maximum copayment on prescription drugs allowed under federal law. These copayments are to be collected by the dispensing pharmacy and credited against the Medicaid payments. Two exemptions from copayments are made: family planning drugs and prescriptions provided for persons involved in the EPSDT (Early and Periodic Screening Diagnosis and Treatment) program.

HB 596, Act 126

Medicaid eligible persons in Alabama pay a $2.00 copayment for any service provided by a physician or other medical practitioner under the Medicaid program. The copayment is to be collected by the provider and credited against the Medicaid payment to the provider.

The Act will not be effective if found to contravene federal Medicaid laws and regulations.

HB 600, Act 156

Recipients of benefits under the Alabama Medicaid program are deemed to have assigned recovery rights for any payments made by third parties. The

Department's recovery is limited to the amount of medical assistance paid by the Medicaid agency.

To implement the Act, Medicaid beneficiaries also are judged to have authorized third parties to release to the Agency all information necessary for recovery.

HB 601, Act 127

This statute provides for terminating or withholding Medicaid eligibility for any recipient who has abused, defrauded or misused the program's benefits. These sanctions may not be lifted until the recipient has made full restitution and remained ineligible for at least one year.

HB 602, Act 113

The sponsor of a nursing home patient receiving medical assistance payments must authorize and assist the county tax collector to receive any earned or unearned income due to the patient. The income must be paid directly to county tax collector and turned over to the Medical Services Administration once a month. In turn, the Medical Services Administration must periodically furnish the tax collector with a list of nursing home patients receiving Medicaid payments in the county.

Supplemental Security Income grants, personal care allowances and sheltered workshop earnings are specifically excluded from the terms of this chapter.

HJR 293, Act 534

This act appropriates $7,000 to the Continuing Select Joint Committee to Study the Rising Cost to the State of the Medicaid Program. This committee was established in the previous session by Act 79-816.

SJR 19, Act 80-153

This Resolution protests the burden and costs of federal regulations on the Medicaid program. The legislature petitions the Federal Congress and executive agencies to allow the States greater leeway to govern their programs. Specifically, the Resolution requests permission to:

1) charge copayments for all services;
2) act as a prudent buyer in purchase negotiations;
3) establish state—rather than federal—standards for staffing medical facilities;
4) deny eligibility to abusers;
5) establish reimbursement methods at a state level;
6) create incentives for effective management;
7) set strict admission policies—to be enforced by PSROs;
8) determine administrative procedures and controls at a state level;
9) charge the agency which erroneously certifies a patient's eligibility the costs incurred by the program;
10) expand family responsibility for costs of patients in nursing homes.

Further recommendations include setting the federal matching ratio at 1970 levels and moving more management functions to the state.

ALASKA

HJR 83

This Resolution spotlights Alaska's problem with adequately compensating physicians for providing Medicaid services. The legislature protests federal rules

that do not take into account the substantial difference in the cost of living in Alaska. The Federal Congress is petitioned to make Medicaid reimbursement more flexible by using local cost-of-living differentials and other methods.

CALIFORNIA

AB 85, Chapter 1160

This law is a continuing authorization and appropriation of a Medi-Cal pilot program comparing patient treatment profiles and prior authorization as controls of utilization in selected areas in California.

AB 1180, Chapter 1008

The state legislature authorizes the Director of the Medi-Cal program to issue Medi-Cal cards to peace officers in order to investigate program fraud or violations of the Medical Practice Act. In the course of an investigation, the cards also may be used by persons working under the immediate supervision of peace officers.

AB 1985, Chapter 947

This law adds to the definition of Medicaid fraud the knowing submission of false information in order to receive greater compensation for furnishing services or merchandise.

Furthermore, the statute makes it a misdemeanor or felony to solicit, receive, offer or pay kickbacks or bribes for referring patients covered by the Medi-Cal program. Another provision forbids adding a charge to a Medi-Cal patient's bill as a precondition of providing the services.

Chapter 947 also prescribes fines and prison terms as sanctions for Medicaid fraud.

AB 2238, Chapter 1173

The Department must disregard the costs of in-home supportive services when measuring income to determine a working disabled person's eligibility for Medi-Cal. This allows persons with incomes slightly above the maximum for supplemental security income to retain medical assistance benefits. "In-home supportive services" are defined as those available to recipients of the In-Home Supportive Services program in California.

AB 2316, Chapter 932

In California payments for Medicaid services are processed through fiscal intermediaries under contract to the Department of Human Services. Under the provisions of Chapter 932, the fiscal intermediaries must submit the documentation necessary to pay providers each Monday morning. The rationale for this action is that providers must receive prompt payment in order to ensure adequate care for beneficiaries.

AB 2495, Chapter 966

Medi-Cal recipients in skilled nursing facilities and intermediate care facilities now may leave the institution as part of a certified special treatment program or a mental health therapeutic and rehabilitation program approved by a local mental health director.

The Department is instructed to develop regulations to implement this therapeutic leave policy. The regulations must include the following provisions:
1) The state will reimburse the facility for maintaining the vacant bed at a rate less

than the normal reimbursement rate.
2) Absences must be in accordance with the patient's plan of care or for a stay in an acute care hospital.
3) The maximum number of days allowed for absences should not be less than 30 a year.

AB 2782, Chapter 303

The Director of the Department must suspend any provider/practitioner from Medi-Cal participation immediately after being notified that the practitioner has been suspended from the Medicare or any Medicaid program due to a criminal conviction.

Persons convicted of noncriminal charges are not to be suspended until any appeals have failed, unless they are deemed a risk to the public. If the Department deems a provider a risk, it must hold hearings on the temporary suspension within 30 days and make a decision within 60 days of the close of the hearings.

Chapter 303 also strikes out sections authorizing the Department of Health Services to visit providers to check the records of services rendered to Medi-Cal beneficiaries.

AB 2845, Chapter 569

The State Department of Health Services and the State Department of Developmental Services are to develop and implement licensing, Medi-Cal and construction regulations for habilitative intermediate care facilities for the developmentally disabled. Two million dollars in state funds are appropriated for the development of community programs and placements for these facilities

SB 148, Chapter 90

Persons residing in a city or county jail or juvenile detention facility may not be denied benefits as long as a federal financial participation is available.

SB 735, Chapter 1322

The California Legislature expanded benefits under the Medi-Cal program to include certified paramedic services provided by or through a city, county or special district.

Moreover, if federal funds are available, the city, county or special district must reimburse the state for its share of the payment for these services. The reimbursement schedule must be based on reasonable costs and updated annually.

SB 1263, Chapter 1240

This law extends the separate Medi-Cal eligibility provisions for persons needing dialysis services who are not income-eligible to include authorization for parenteral hyperalimentation services.

SB 1356, Chapter 43

Chapter 43 authorized the Joint Legislative Audit Committee to investigate the implementation of Medi-Cal contracts with providers in order to identify problems with claims-processing procedures.

In addition, the Joint Legislative Budget Committee shall monitor the Department's claims procedures and make monthly reports to the legislature. Both committees are given access to the Department's records of disbursements, including those identifying recipients by name.

Change orders or amendments to the Department's contract with providers require approval of the Chairman of the Appropriations Committee of both houses or the Chairman of the Joint Legislative Budget Committee.

SB 1635, Chapter 890

The Medi-Cal program sets annual prospective reimbursement rates for beneficiaries in prepaid health plans. This act provides for interim payments if the Department and plans are not able to agree on a rate and gain state approval prior to the expiration of the previous rate on July 1 of each year. Between July 1 and September 1 the Department will continue to pay at the old rate and adjust its payments when the new rate is in place. After September 1 if the Department and prepaid group plans have assented to a change and are waiting for approval of various state control boards, the new per capita rate will be in force. Any necessary adjustments will take place after all approvals have been made.

In addition, this Act requires that per capita rates be determined by sound actuarial methods on the basis of age, sex and aid categories.

SB 1637, Chapter 1044

Medicaid recipients in counties served by an eligible prepaid health plan must be informed of their option to choose between individual providers and a prepaid health plan. Until making a choice recipients will be served by individual practitioners.

The Department is given the responsibility to establish a program that includes:

1) a method of informing applicants/beneficiaries about prepaid health plans (The Department may edit or prescribe the format for any literature provided by fee-for-service practitioners and prepaid health plans.);
2) the provision of information necessary to explain choices;
3) the provision of lists of physicians and other providers who accept Medicaid patients;
4) training for county employees to implement the program;
5) monitoring implementation to see that well-informed choices are made;
6) the establishment of a schedule for phasing in the program;
7) an annual survey of beneficiary choices and satisfaction with the benefits.

SB 1650, Chapter 891

All nursing home patients not receiving Medi-Cal benefits must be given 30 days notice of any room rate increase. However, the facility need not provide the notice if the delay would result in a loss of Medi-Cal reimbursement (i.e., if funds are issued on an emergency or retroactive basis). However, in that case the facility must give as much notice as possible. The provisions of this law do not allow long-term care facilities to impose retroactive rate increases on non-Medicaid beneficiaries.

SB 1697, Chapter 1323

Medi-Cal may contract with prepaid health plans to provide services for Medicaid beneficiaries. SB 1697 expands the definition of prepaid health plans to include nonprofit hospital service plans.

SB 1739, Chapter 1075

Medi-Cal patients requiring continuous service or observation during transfer between acute care facilities must be transported by ambulance. Patients

in nonemergency situations may be moved in other medical transportation vehicles.

This law also extends indefinitely the prohibition keeping cities and counties from establishing regulations for Medi-Cal medical transport services that conflict with State Department of Health Services standards.

SB 1766

This law regulates Medi-Cal's contracts with prepaid health plans.

Public notice must be given 30 days prior to any action taken on the contract, including amendment, renewal and implementation. Any person affected by the action may request a hearing; the request must be approved by the State Director of Health Services.

According to these amendments the Department must renew a contract unless good cause is shown for nonrenewal. However, the Director is empowered to levy sanctions against a contractor short of termination of the contract. Reasonable notice of the sanctions must be given to interested parties.

Although prepaid health plans with Medicaid contracts still must provide the Department with statistical information to enable the Department to set reimbursement rates, this information is no longer included in reports to the legislature.

AJR 71

The California Assembly petitioned the U.S. Congress to amend the Social Security Act to include adult day health care centers as approved providers for Medicare and Medicaid Services. The Resolution points out the benevolence and cost-effectiveness of this measure.

CONNECTICUT

HB 5116, PA 80-50

For purposes of eligibility determination, children under 21 who live with their parents are deemed to have access to parental income and resources.

HB 5121, PA 80-63

This legislation requires persons legally liable for the care of a dependent child or persons receiving an award for the care of a child to notify the Commissioner within 15 days of receiving property, wages, income or resources. Moreover, such persons may not sell, transfer or dispose of any property without the consent of the Commissioner.

Any change in the information noted on the applicant's eligibility form must be reported, in writing, within 15 days of the change.

HB 5545, PA 80-170

A nursing home in Connecticut must retain the bed of a hospitalized resident as long as payment is available. If payment is not available for the full hospitalization period, the home must provide the returning resident with the first available bed or lose all reimbursement for the time the patient was hospitalized. This law also permits a long-term care facility to charge a fee to retain the bed after the Department ceases to pay; this fee may not exceed the facility's daily rate for self-pay patients.

The Department of Income Maintenance will reimburse a nursing home at the usual per diem rate for a maximum of six days. Ten additional days may be

reimbursed if reserving a bed will produce a cost saving for the Department.

The facility should get prior approval for scheduled hospitalization. Emergency admissions must be authorized by the Department on the first business day after the admission.

HB 5548, PA 80-364

This law bans discrimination by nursing homes against those receiving medical assistance benefits from the state or a town. Nursing homes must:

- admit patients in order of application;
- keep a daily log of requests for admission, the number of vacancies, the number of admissions and the number of indigent admissions;
- not require patients to post any money or make an obligation to pay; and
- post a notice describing the requirements of this act.

Regional ombudsmen are authorized to conduct investigations relating to compliance with the statute and the Department of Income Maintenance is empowered to reduce reimbursement for a year after finding a violation (¼ of 1% for the first violation and 1% for each additional violation).

DELAWARE

HB 1176, Chapter 424

In order to offset large cost increases, fill the urgent need for the health care provided in state institutions and maximize the availability of matching federal grants, the Delaware Assembly made a supplemental appropriation of $9.4 million to the Department of Health and Social Services.

FLORIDA

HB 1312, Chapter 206

Chapter 80-206 sets out the authority of the Auditor General's Office to deal with Medicaid fraud. The major responsibilities of the unit are: 1) investigating possible criminal violations of any state law pertaining to medical assistance; 2) examining alleged abuses of patients or misappropriation of patients' private funds in health care facilities receiving payments under Medicaid. The office must refer violations to the state attorney and inform the Department of Health and Rehabilitative Services of any potential noncriminal abusive activities or overpayments to providers unearthed during an investigation. Finally, the Auditor General has a responsibility to protect the privacy of records and individuals.

To fulfill these functions the Auditor General's staff may enter the premises of medical assistance providers (except physicians) to examine records; participating physicians must make accounts and records available to investigators. The records of non-Medicaid patients are specifically excluded.

HB 1812, Chapter 408

This chapter makes a number of changes in various sections of Florida's Medicaid legislation.

The most important changes involve administrative sanctions for providers convicted of Medicaid fraud. Sanctions include termination from participation in the program, suspension from the program for up to one year, fines up to $500 for each violation (up to $10,000), mandatory prepayment review for all claims, or required attendance at a provider education program. The law also lists the

criteria for determining the appropriate sanction. These penalties may be imposed for the following offenses:

1) conviction of Medicaid fraud (requires termination from participation);
2) conviction of a state or federal offense relating to Medicaid practice;
3) suspension or termination from the Medicare program for cause;
4) revocation, suspension, termination or nonrenewal for cause of the provider's license in any state;
5) expiration, suspension or termination of the provider's certificate of participation in the Medicare program;
6) failure to provide access to records to proper authorities;
7) noncompliance with state and federal Medicaid rules and regulations;
8) failure to comply with conditions of participation;
9) ordering or furnishing goods or services to a recipient that are deemed by competent peer evaluation to be excessive, harmful or of inferior quality;
10) submission of false information to the Medicaid program in order to obtain higher reimbursement; and
11) collection from recipients for services paid for by Medicaid.

A provider indicted for fraudulent billing or negligent practice resulting in the death or injury of a patient may be suspended from the program for the period of the indictment. Moreover, Medicaid payments received as a result of a violation may be withheld during the investigation as long as not more than 10% of the monthly Medicaid payment is held back. This amount plus 10% interest must be paid within 10 days if no violation is found.

Chapter 408 also sets out the process that the Department must use if it alleges that an overpayment has been made: if an overpayment is discovered, the Department may charge the provider 10% interest.

The law also refers to the provision of hearing aids. Audiologists are removed from the list of covered providers. A non-ear specialist must refer patients to an ear specialist before a hearing aid may be provided through Medicaid. Finally, the Department may contract for the bulk purchase of hearing aids and the related dispensing service and repair functions if it is found to be less expensive.

Interest income on savings accounts under $1,000 is no longer excluded from assets in determining eligibility.

SB 954, Chapter 184

The Florida Legislature extended for one year a pilot program to test the feasibility of increasing hospital outpatient service benefits through local agency contributions to the medical assistance program.

SB 1218, Chapter 186

This statute affirms the right of nursing home patients to make overnight visits outside the facility without losing their beds, provided they comply with facility, physician, Medicare and Medicaid rules and regulations.

A facility certified to provide Medicaid services may not transfer or discharge patients solely because their source of payment changes, unless the facility makes a reasonable effort to place the patients in an appropriate setting. When a patient's patient-facility contract expires or source of payment changes, a new patient-facility contract listing all charges and supplies not covered by Medicaid and Medicare must be established.

HAWAII

HB 2064, Act 210

The Hawaii Legislature added a section to the State's Medicaid fraud statute which makes a violation of the statute a Class C felony.

The definition of Medicaid fraud is expanded to include making false statements or misrepresentations in payment applications in order to obtain greater compensation than allowed or authorization to furnish services and supplies.

This Act explicitly does not preclude the use of any other applicable criminal or civil remedy.

HR 148

This Hawaii Resolution calls for the federal government to assume a greater share of the cost of long-term care in skilled nursing and intermediate care facilities. The legislature is concerned about the large portion (approximately ⅓) of the Medicaid budget that is spent on long-term care.

Options offered for federal consideration include:

1) increase benefits under Medicare;
2) increase the federal match in the Medicaid program; and
3) increase benefits/eligibility on federal public assistance.

SR 287

The Director of Social Services is enjoined by this Resolution to work with the federal Health Care Financing Administration to conduct a seminar on problems affecting the Medicaid program. The Resolution also indicates appropriate participants and topics for the seminar.

SR 289

The Hawaii Legislature maintains that Medicaid cost containment is not possible without health care system cost containment. Identifying Medicaid cost increases as a major problem, SR 289 creates an interim task force to study cost containment efforts in other States, specifically mentioning a variety of strategies including rate review, competition, health promotion and consumer education.

SR 303

The Director of Social Services is enjoined by this Act to initiate a study on the feasibility of instituting copayments for certain services and limitations on all services. The Act specifically includes emergency room services. Moreover, special attention is directed to studying cost sharing plans in other States.

IDAHO

SJM 107

The Idaho Legislature petitioned the Federal Congress to amend the Social Security Act to deny Medicaid payments to those who dispose of assets in order to qualify for assistance.

ILLINOIS

SB 1978

This law changes eligibility standards for Medicaid benefits in Illinois. In order to receive medical assistance, a person's income now must be less than the

"grant amount" rather than the "basic maintenance need"; both amounts are established by the Illinois Department.

In addition, a new section was added that requires the Department to set up new conditions and standards for payments for care provided to medical assistance recipients in skilled nursing facilities and intermediate care facilities. The conditions and standards must be consistent with federal criteria.

INDIANA

HB 1117, PL 90

Indiana changed its family responsibility requirement for spouses and parents from those "able" to pay part of medical bills to those "having sufficient income" to do so. PL 90 also removes from the eligibility rolls blind and disabled 18-21 year olds who are not in school or other training.

Life insurance policies, prepaid funeral plans and irrevocable trusts under $1,000 are not included in the Department's determination of eligibility.

This law also formulates an equation to determine the income of persons in sheltered care or day activity workshops. These people receive the same personal allowance as those in residential care (between $28.50 amd $35.00 a month) and ½ of the total of earned income plus withheld taxes plus transportation expenses minus $16.00.

SB 118

SB 118 revises Indiana's Medicaid eligibility provisions. Under the previous legislation assets belonging to the recipient and one parent over $1,500 ($2,500 in a two-parent family) disqualified him/her for medical assistance. SB 118 provides that only the parents' excess over $1,500 (single parent) or $2,500 (two parents) is added to the recipient's funds to determine program eligibility.

Senate Enrolled Act 352

This Act tightens the provisions of a 1979 law (PL 126) covering medical assistance for nursing home residents. All residents no longer receive personal allowances—only those receiving Medicaid assistance. Also, a residential facility must obtain a license or provisional license in order to operate and collect Medicaid funds.

SB 391

This law establishes a demonstration project to fund home health care under Medicaid. Persons receiving benefits under this demonstration must be over 60 and a medical assistance applicant or recipient or, if not currently eligible for Medicaid, likely to become eligible if institutionalized because home health care is unavailable.

The monthly cost of the home health services may not exceed 75% of the cost of institutionalization for each participant in the demonstration program. SB 391 also makes a $125,000 appropriation to the committee established to coordinate the program.

IOWA

HB 402

An attorney's responsibility to provide adequate notice of action on a claim in which the Medicaid Department has an interest is fulfilled by sending such notice through the U.S. mails.

HB 685

This law expands Iowa's definition of Medicaid fraud to include persons who transfer property at less than fair consideration in order to become eligible for public assistance as well as those who accept the transfer with the intent of enabling the party transferring the property to obtain public assistance.

A transfer of property during the year prior to application for benefits is evidence of an attempt to obtain coverage fraudulently. The maximum sentence that may be imposed for offenses under this Act is the penalty for a serious misdemeanor.

HB 2580

Iowa's Budget Act addressed a number of Medicaid issues along with several unrelated health matters.

Two changes deal with reimbursement rates. This law raises maximum cost-related reimbursement for residential care facilities from $13.50 to $14.00 a day and the flat rate from $8.00 to $9.00 a day. Also, a new section establishes the 74th percentile of facility per diems as the maximum medical assistance payment rate for intermediate care facilities.

The maximum income for medically needy is changed from $600 a month to 300% of the maximum individual payment under the federal Supplemental Security Income program.

In addition, this law amends the State's insurance code to mandate that private health insurers may not exclude employees, spouses or dependents from coverage because of their eligibility for medical assistance.

The Department is directed to adopt rules to::

1) change the effective date of assistance to less than seven days after the application date;
2) eliminate payment for laxative drugs;
3) limit orthodontia to injuries and emergencies;
4) limit types of eyeglass frames;
5) extend period between eligibility to obtain new glasses (except emergencies);
6) limit replacement of dentures to every five years (except emergencies)
7) reimburse for hearing aids at cost and dispensing fees;
8) establish coinsurance for the following optional services—dental, optometry, audiology, orthopedic shoes, hearing aids and medical equipment;
9) establish a $.50 per prescription copayment; and
10) require pharmacists who reduce charges on prescription drugs or insulin for third party payers to reduce them by the same amount for Medicaid.

Finally, the Department must arrange for a study of alternative methods of reimbursement for long-term care.

KENTUCKY

SB 53

SB 53 amends Kentucky's statute on reimbursement under the Medicaid program. Prior to its enactment provider payments could vary geographically and among providers. This law stipulates that maximum amounts reimbursable for similar services by in-state physicians in the same specialty may not vary according to their practice locale.

SB 205

The purpose of this act is to develop a third party liability program in compliance with Title XIX of the Federal Social Security Act and to ensure that the medical assistance program is the payer of last resort in Kentucky.

First, vendors of medical services must submit billings to third party payers (if aware of them) prior to sending them to Medicaid.

Second, an applicant for benefits is deemed to have assigned rights for third party recovery of Medicaid benefits to the Medicaid Department. The Department also may institute or join in legal proceedings against third parties. Recipients bringing legal proceedings without the Department's participation must keep the Department informed of the commencement and settlement of the case, at the minimum

In addition, if a child is eligible for Medicaid because of an absent parent, the Department may institute a civil action to regain any medical assistance payments.

Other provisions mandate that:

1) Insurers may not reduce or deny benefits because of a patient's eligibility or coverage under Medicaid.
2) If the Department and the beneficiary bring a joint suit, the attorney's part of the Department's share may not exceed 25%. The amount recovered by the Department may not be included in the computation of the patient's legal fees.

HR 109

This resolution was passed because of the drastically increasing costs of Kentucky's Medicaid program (86% overall increase and a 375% rise in the intermediate care component between 1975 and 1979) in spite of a slight decrease in the number of medical assistance recipients. It also is noted that eligibility levels have not changed since 1974.

The Legislative Research Commission is requested to study the program with special emphasis on its adequacy and strategies to reduce or contain costs or increase provider acceptance.

The Commission must present its findings to the 1982 General Assembly.

LOUISIANA

HB 1450, Chapter 255

A person who applies for, becomes eligible for, or accepts medical assistance is deemed to have made an assignment to the Department of any hospitalization, accident, medical or health benefits available for the services. Children eligible for or receiving benefits have also assigned the rights to any benefits available to them.

HB 1686, Act 769

Recipients of Medicaid benefits are responsible for informing the Department of Health and Human Services of any changes in their personal circumstances, including:

1) members of the household;
2) residence of the recipient;
3) establishment of a legal/nonlegal union by the recipient; and
4) failure of a child between 16 and 18 receiving AFDC benefits to attend school regularly.

If a recipient receives more benefits than entitled to because of failure to report these changes he or his estate must repay the overage with legal interest. Moreover, persons receiving medical assistance fraudulently are suspended from the medical assistance program for 12 months.

SB 209, Act 481

Louisiana's SB 209 mandates the expansion of the state Medicaid program to include persons who are no longer eligible for SSI because of cost-of-living increases in state or local retirement benefits. The law is in force for persons who became ineligible for SSI since August 31, 1979.

HCR 65

The Legislature enjoins the Department of Health and Human Resources to provide financial assistance for the services of licensed podiatrists; these currently are unavailable to qualified recipients.

HCR 80

The Louisiana Legislature is petitioning the Federal Congress to exclude Social Security benefits from an elderly person's determination of income. This Act is put forth because of the Legislature's finding that elderly persons whose incomes are slightly above eligibility limits for Medicaid are still medically needy.

SCR 24

The Congress is requested to examine the needs of the medically needy and to consider increasing the maximum income for receiving benefits under Titles XV and XIX. The purpose behind this action is to help the aged, blind and handicapped with incomes over $228 a month who do not qualify for medical assistance.

SCR 126

Louisiana's medical assistance program currently does not cover the use of oxygen on a continuing nonemergency basis in homes or nursing homes. The Legislature suggests that this stems from fear of liability from accidents and offers evidence to dispute this fear. Furthermore, the Resolution notes that the cost to the State could be as low as $50 a month per patient because federal programs partially cover the use of oxygen.

A Joint Legislative Committee, made up of members of the House and Senate Health and Welfare Committees, is established to study the feasibility of including these costs under the Medicaid program. The Committee's report is due prior to the opening of the 1981 session.

SCR 133

At present $25 a month is paid to nursing home residents under SSI, while those who are ineligible for SSI but receive state medical assistance payments may retain $25 for personal expenses. Since the personal allowance has not been increased in several years, the Department of Health and Human Resources is requested to reevaluate the personal needs allowance and make every effort to increase it at the state level, as well as to influence federal legislative and executive officials to increase the federal allotment.

MAINE

SB 709, Chapter 610

This law relates to the Department's powers to recover Medicaid payments made for injuries caused by a third party. The term "injuries" is expanded to include diseases, disabilities and other similar occurrances.

MARYLAND

HB 137, Chapter 845

This statute amends current Maryland law dealing with involuntary removal of Medicaid patients from SNFs and ICFs participating in Medicaid. It adds transferring assets for the sole purpose of receiving medical assistance to the list of reasons why a resident may be involuntarily transferred or discharged from a long-term care facility.

Two other sections strengthen safeguards for Medicaid patients. A Medicaid-certified facility may not require a patient to pay costs out-of-pocket for at least a year before becoming Medicaid eligible as a condition for admission or continuance in the facility. Moreover, changing from private pay to Medicaid reimbursement does not constitute nonpayment of facility charges and any Medicaid-certified facility that attempts to transfer or discharge a resident who is, or will become a Medicaid patient is presumed to be doing it for an unallowable cause.

In addition, the Department shall conduct a study concerning appropriate reimbursement methodologies for nursing homes under the medical assistance program as well as payment rates to proprietary nursing homes that include a fair rate of return.

HB 339, Chapter 384

Information on public assistance recipients (including medical assistance) may be released only under a court order or to an authorized officer or employee of the State as necessary to perform his/her job. Prior to these amendments the law specified the information that may not be divulged to other persons about public assistance recipients. Currently no information about recipients may be given out except under the above circumstances.

HB 965, Chapter 97

Maryland established a three year statute of limitations for the prosecution of Medicaid fraud.

HB 1726, Chapter 800

The Maryland Medicaid program is required to reimburse an extended care facility (ECF), a skilled nursing facility (SNF), an intermediate care facility (ICF) and a comprehensive care facility in the same manner as a hospital if the facility is licensed as a distinct but hospital-related institution as of July 1, 1980.

The law only applies to the extent that federal funds are available.

SB 542, Chapter 324

SB 542 deals with inmates of public institutions who are eligible for federally-funded Medicaid benefits. These inmates are eligible for Medicaid payments for services provided by the institution. However, the law provides that the institution's state or local authority must reimburse the department for the nonfederal share of the medical assistance.

HJR 83

HJR 83 constitutes a legislative commission to study general aspects of the Medicaid program in Maryland. The Resolution mandates the makeup of the commission and instructs the members to focus on needs assessments and program guidelines and priorities. The final report is due at the beginning of the 1982 legislative session.

MICHIGAN

HB 5199

This law deletes sex-specific language from Michigan's legislation on eligibility for medical assistance.

HB 5875, PA 391

Michigan passed legislation affecting covered services and state/county responsibilities for financing Medicaid care.

This law requires that transportation and nursing services be related to medical, surgical or obstetrical care in order to be covered.

In addition, the Department will pay for hospital and nursing home services in accordance with a DHHS-approved state plan. However, counties must reimburse the State 90% of the county rate for services provided by county-owned and -operated facilities.

MINNESOTA

SB 702, Chapter 575

This law establishes a nursing home preadmission screening process for Medicaid patients or those who will become eligible for medical assistance within 90 days of admission. Counties either may establish their own screening teams or contract out the responsibility to a private or public agency. The composition of the team and conflict-of-interest rules for team members are prescribed in this Chapter.

The duties of the screening teams include:

1) providing information about the screening team to the public;
2) assessing the health and social needs of referred individuals with the intention of maintaining them in the least restrictive environment;
3) identifying noninstitutional services meeting clients needs;
4) recommending nursing home admission or home care; and
5) providing follow-up services, as necessary.

Patients transferring from acute care facilities or other nursing homes need not go through the screening process. However, non-Medicaid patients may pay a fee (assessed on a sliding scale) to receive the services of the screening panel. Screening services for Medicaid-eligibles will be paid for out of medical assistance funds.

If the individual's physician does not agree with the findings of the screening, the screening team's decision is automatically sent for appeal. Otherwise, the Department will not pay for services for patients placed in a facility contrary to the panel's recommendation. The law includes two exceptions—emergency admissions when the screening team has not made a decision within five working days, and instances where a beneficiary needs long-term supportive services which are not available in the community.

MISSISSIPPI

HB 399, Chapter 504

HB 399 pertains to reimbursement for pharmaceuticals under the Mississippi Medicaid program. Primarily, the Commission is authorized to pay for drugs as if they were dispensed on a generic basis. Reimbursement levels are also established;

the Commission will pay the lower of ingredient costs plus a reasonable dispensing fee, or the provider's usual, customary and reasonable charge.

Finally, the Commission must survey pharmacies from time to time to collect data used for establishing reasonable dispensing fees.

HB 1324

The Legislature appropriated $58.5 million and authorized $188.2 million of federal money to be spent for medical assistance and administration of the program.

MISSOURI

HB 1840

In order to expedite Medicaid payments to hospitals, nursing homes and other providers, this Act permits the Department to pay for services by wire transfer rather than by check.

SB 588

Missouri's Senate Bill 588 expands both eligibility and treatment providers in the Medicaid program.

Pregnant women who would be eligible for AFDC payments if the child already had been born are deemed eligible for Medicaid benefits. In addition, surgical and presurgical services provided in an ambulatory surgical facility (surgicenter) are eligible for reimbursement by Medicaid.

NEW MEXICO

HB 144, Chapter 86

This law deals with conflict-of-interest requirements for employees of the Human Services Department who have a substantial role in the Medicaid decision-making process.

No former employee with policy-making responsibility may act as an agent for a business in any area where he/she had been substantially involved or responsible. Former senior officials may not participate in any judicial or administrative proceedings pending before the Department for two years. Moreover, no employee with policy responsibility may participate in any proceeding in which he/she has a financial interest unless a full disclosure has been made and the Department has approved participation.

Sanctions for employees include dismissal, demotion or suspension. Former employees may be fined up to $250 for each violation.

NEW YORK

SB 9800-A, Chapter 336

In 1980 New York passed legislation separating the standard of care compliance examination and the financial audit components of nursing home inspections.

The Department shall conduct an on-site audit of the financial records of each fiscal year used in the determination of reimbursable costs and patient rights. Except for instances involving reimbursement rate appeals, nursing home financial records for any fiscal year may not be subject to more than one on-site audit.

NORTH CAROLINA

HB 1590, Chapter 1270

North Carolina appropriated $50,000 to establish a computerized eligibility system for public assistance programs in the Divisions of Social Services and Medical Assistance.

HB 1731, Chapter 1288

This law appropriates $127,540 for the purpose of increasing the dispensing fee paid to pharmacists from $2.68 to $2.80 per prescription (excluding refills).

HB 1762, Chapter 1297

Chapter 1297 authorizes the Department of Human Services to purchase health services on a prepaid basis for medical assistance beneficiaries. This Act is subject to the approval of a change in the State Medicaid Plan by the Director of the Budget and the Advisory Services Budget Commission.

SB 940, Chapter 1312

Acceptance of medical assistance benefits indicates that the recipient has assigned any third party benefits to the state. The state or county providing medical assistance is given the right to recover payments from the beneficiary, his heirs, his personal representative or the executor of his estate.

This section is enforced by the county attorney or an attorney retained by the county or the state.

OHIO

HB 176

This act is a major revision of Ohio's Medicaid nursing home reimbursement system. Generally, it is an attempt to make quality considerations part of reimbursement policy and, also, to pay for only those services related to patient care at a rate commensurate with patient medical needs. Specific provisions define and limit various areas of nursing home costs:

- nursing and habitation—based on an assessment of actual patient needs as determined by the Department of Public Welfare;
- dietary—determined according to raw food costs established by the U.S. Department of Agriculture;
- utility costs and property taxes;
- administration and general services—per diem rate equal to the median, plus four-fifths of one standard deviation from the median, of the preceding year's actual audited allowable expenditures; and
- property costs—defined as the actual straight line depreciation costs over 40 years for buildings and consistent with IRS guidelines for equipment, subject to a maximum limit according to cost and date of construction.

The per diem rates for each home will be adjusted annually following audits of actual expenditures. If the actual costs of nursing and habitation, diet, and utility costs and property taxes are higher than the per diem rate, homes will be reimbursed the difference. If the rate paid for these cost centers is greater than the actual cost, that amount is to be refunded to the state.

Facilities not having a provider agreement with the Medicaid program must provide prospective residents and their sponsors with the following notice prior to admission.

"This home is not a participant in the medical assistance program administered by the Ohio Department of Public Welfare. Consequently, you may be discharged from this home if you are unable to pay for the services provided by this home."

A home may not terminate its Medicaid participation status without giving at least 90 days notice to the Department, residents and their sponsors. However, the Department may terminate the arrangement without such notice. HB 176 also gives residents, sponsors and resident rights advocates standing to sue facilities for breach of duty if a patient is discharged improperly (without satisfactory transfer arrangements).

Therapeutic leave requirements also are revised. Rather than 12 days for hospital stays and 12 days with friends or therapeutic programs, residents may now take 24 days of therapeutic leave without jeopardizing their place in a nursing home.

HB 964

In Ohio, therapeutic leave for long-term care patients is limited to 24 days in a 12-month period. HB 964 exempts ICFs/MR from this maximum period in which payments will be made to reserve a patient's bed. However, the Act stipulates that the leave must be provided for in the patient's plan of care and federal financial participation must be available.

Funds are appropriated to carry out the provisions of this act.

PENNSYLVANIA

HB 522

This statute refers to fraud and abuse activities. The largest part of the legislation regulates the activities of shared health facilities (groups of three or more practitioners in two or more professions who share space, charge fee-for-service in whole or in part, and receive at least $30,000 in Medicaid funds per year).

Shared health facilities must register with the Department and establish a uniform system of reports and audits. Informational requirements include changes in ownership or persons holding security interests or central administrative responsibility as well as changes in participating practitioners. HB 522 also establishes minimum care requirements for shared health facilities. In the Medicaid fraud area, HB 522 prohibits the following activities:

1) bribes and kickbacks;
2) demanding or collecting reimbursement contrary to the medical assistance program fee schedule;
3) providing goods, services or equipment differing from that shown on the invoice or prescribed by the provider; and
4) referring patients within the shared health facility without medical justification.

In addition, all medical facilities must disclose the name, Social Security number and criminal record (if any) of persons who own or control more than 5% of a facility. All providers must maintain medical and financial records used to support reimbursement claims for at least four years. Similarly, SNFs and ICFs must maintain records of expenditures from Medicaid recipients' personal funds. Finally, providers may not assign the rights to Medicaid payments to any third party.

Recipient fraud also is addressed in this enactment. Applicants and recipients must prove that any transfer of assets in the two preceeding years was an arm's-length transfer for fair market value.

HB 522 reaffirms that patients have freedom-of-choice in the selection of providers. Providers may refuse to treat a Medicaid recipient but may not discriminate on the basis of sex, race, creed, color, national origin or handicap.

RHODE ISLAND

HB 9003, Chapter 411

The Rhode Island Legislature appropriated $244,977 in order to increase the personal living allowance of Medicaid recipients in medical, nursing and intermediate care facilities. The allowance, which had been $25 a month since 1974, is raised to $30.

SOUTH DAKOTA

SB 196

This Law appropriates $43,316 to treat dental problems of Medicaid-eligibles over 21. Moreover, the Department is authorized to accept $95,428 in matching federal funds under Title XIX to fund this dental program.

TENNESSEE

HB 1676, Chapter 535

The state is given recovery rights to all applicable third party reimbursement to the extent that Medicaid benefits have been paid. By the act of accepting medical assistance, a beneficiary is deemed to have assigned recovery rights to the State; failure to reimburse the State for any benefits may cause a recipient to lose Medicaid entitlement.

This Act specifically protects insurance companies from paying both the State and the recipient and prevents the Department from seeking recovery from providers if the third party funds were obtained without their knowledge or direct assistance.

In addition, unless the Department has given the beneficiary's attorney prior notice of its recovery claim, the attorney is not liable for the State's recovery claims.

HB 2324, Chapter 663

Among other provisions relating to the Primary Health Care Advisory Board, HB 2324 outlines the duties of the Board. One of these duties is to recommend whether a primary care center should be deemed a community health clinic and receive Medicaid provider status.

Medicaid HJR 703

This Resolution directs the Department of Human Services to conduct a study of the medical assistance program in Tennessee. The legislation specifically mandates that the study focus on eligibility criteria and the need to reduce unnecessary utilization of hospital services. The Department is to propose alternatives designed to reduce utilization without endangering the health or welfare of Medicaid recipients.

Study results were to have been be reported to the Chairmen of the House and Senate Finance and Ways and Means Committees prior to February 1, 1981.

HJR 705

The Department of Public Health is directed to conduct a thorough study of the feasibility of requiring certification for nonemergency Medicaid admissions. Similar efforts in other States are to be reviewed with a special emphasis on:
1) the health of Medicaid recipients;
2) occupancy of hospitals;
3) expenditures for hospital services under Medicaid; and
4) expenditures for other services under Medicaid.

The report of the Commissioner of the Department was due by February 1, 1981.

UTAH

SB 53

Counties in Utah are required to pay for medical care for their indigent recipients. This law stipulates that a county need not provide for payment if a person qualifies for the state medical assistance program, the Hill-Burton Uncompensated Care Program, or Titles XVIII or XIX (Medicaid) of the Social Security Act.

VIRGINIA

SJR 85

The Board of Health in Virginia is requested to reassess its current rules on transfers of property and Medicaid eligibility because the legislature is concerned about abuse. The Board is required to consider rules to eliminate incentives to transfer assets to avoid using them to pay for medical care. The implication of the legislation is that the current one-year denial of benefits after a transfer is not a sufficient disincentive.

The Board's report and recommendations to the legislative and executive branches was required by December 1980.

WASHINGTON

HB 1458, Chapter 79

Under this new legislation the Department shall allow recipients to retain wages received for work in a training or rehabilitation program designed to prepare the recipient for placement in a less restrictive setting.

Additional sections provide that AFDC and general assistance will not be awarded to persons who have transferred assets in order to obtain or retain benefits. The Department presumes that a person who transfers property at less than full value does so for the purpose of becoming eligible for assistance.

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